

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034650

FILED VS. OCT 3 1960 149

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 4695

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | Length of stay in lb <u>40 yrs</u> | | c. CITY OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) <u>General Hosp</u> | | | | d. STREET ADDRESS (If outside, give location) <u>4144 Warwick</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Leona</u> Middle <u>Burroughs</u> Last <u>Burroughs</u> | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>60</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/20/90</u> | 9. AGE (last birthday) <u>70</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (City and state or country) <u>O'Fallon, Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>James Wilmore</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mamie (?)</u> | | 14. NAME OF HUSBAND OR WIFE <u>Chas. A. Burroughs</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>May McBroom 4144 Warwick</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>infarction</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. CITY, TOWN, OR LOCATION <u> </u> | | COUNTY <u> </u> | STATE <u> </u> |
| 21. I attended the deceased from <u>9-12-60 3:50 p.m.</u> to <u>9-12-60</u> and last saw her alive on <u>9-12-60</u> Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>H. L. Dwyer MD</u> (Degree or title) | | | | 22b. ADDRESS <u>2400 Cherry City</u> | | 22c. DATE SIGNED <u>9/12/60</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>9/14/1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | | 23d. LOCATION (City, town, or county) (State) <u>K. C. Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Wells & Co.</u> | | ADDRESS <u>1800 E. Lincoln</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-15-60</u> | | 26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u> | |

DOCUMENT

H. L. Dwyer MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Arthur Eugene Hood

Licensed Embalmer No. 4912

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.